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SOME NEW TRENDS IN HEALTH EDUCATION

PRESENT CONCEPTIONS OF EDUCATION AND HEALTH

Not so long ago it was urged that education was a preparation for life. In due time education came to mean life itself, but now it is called a way of life. Health education, then, "is a way of living which produces at each stage an important, wholesome type of living." Health habits, attitudes, and information must be acquired from purposeful, functional situations if they are to be effective. Education in general and health education in particular are concerned with the individual in his total development. They are bound up with all the home, school, and community situations to which the individual responds.

HEIGHT AND WEIGHT MEASUREMENT

In earlier days of health emphasis in education, great stress was placed upon height and weight. Educators were misled in their efforts by the popularity of central tendencies in educational measurement. When it became evident that much harm might arise from comparing all individuals with norms, there was a tendency to scrap the whole practice of weighing and measuring. In moving so far in that direction those interested in health education disregarded

some of the most important health motives. The child wants to grow and is delighted to know that he is achieving this purpose. By the new emphasis on height and weight the child is allowed to check his own behavior and is reminded of the things he has decided he wants to do. A child should know how much he has gained in height and weight during a significant period of time.

HEALTH EDUCATION FOR EDUCATORS

The health movement in education has been seriously retarded by the need for health education among school officials and teachers. Educators themselves have needed education in personal health as well as a clear understanding of their proper functions in promoting health in the school and community. It has occasionally been noted that the percentage of school attendance among teachers has been lower than that expected of children.

It is most gratifying that the need for health education among teachers is being met in all teacher-training institutions. The former physical-training teachers have broadened their functions to include physical education and health.

HEALTH EDUCATION FOR ADULTS

Dean Payne points out that achievement in health education has been fully realized among children. That emphasis will be continued in the light of new knowledge and improved practices. Most encouraging also is the movement to increase life expectancy among adults.

Persistent have been the efforts of society through education and legal measures to reduce the number of deaths and serious accidents on our highways. Until very recently, however, we heard little about venereal disease. Automobiles killed 1,107 and injured 26,185 people in New Jersey during 1936. Yet venereal disease caused 3,700 deaths and brought disability to 200,000 others during the same period.

With such facts in mind it is easy to understand why physicians, bacteriologists, nurses, and social workers throughout the United States are determined to apply against the disease the best procedures that science and experience have evolved. The battle is on in State and local departments of health, in coöperation with the United States Public Health Service, to conquer venereal disease.

THE PREVENTIVE MEDICAL PROGRAM

Another important trend is illustrated by the Detroit plan in which physicians participate actively in official public-health procedure. The ultimate objective of this plan has been to secure the sympathetic and wholehearted support of the medical profession, thus providing for both a curative and a preventive medical program. It is the growing belief that the proper course lies in the direction of making the practice of medicine contribute to health education. Eventually, it is hoped, the physician will be employed to keep people well rather than just to cure them after they become ill.

The immediate objectives of the Detroit plan as described by Dr. Henry F. Vaughan,¹ Commissioner in the Department of Health, Detroit, Michigan, are: "(1) The protection of a high percentage of children between six months and ten years of age against diphtheria; (2) vaccination against smallpox; (3) periodic health examination; and (4) periodic dental examination."

IRA M. GAST

¹ *Advances in Health Education* (New York: American Child Health Association, 1934), page 179.

THE SCHOOLS AND CHILD HEALTH

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In scanning the pages of history it would be difficult to find a chapter that is more dramatic than that relating to the public-health movement and the improvement of health conditions in the world, especially in the United States, during the past half century. A single example tells the story of this achievement. In 1901 the infant mortality rate in New York City was two hundred ten deaths in every one thousand births; for the year 1936 the number was fifty-five in a thousand; and for recent months the rate was around thirty. This is indicative of what has happened in the case of communicable disease which attacks all ages of the population. Public-health effort has to its credit the control of yellow fever, smallpox, typhoid, diphtheria, scarlet fever, and tuberculosis. Other diseases, if not under control, are vanishing. When we seek to discover the secret of this amazing achievement, we think of the heroes of science—Pasteur, Lister, Koch, Reed, Trudeau, Gorgas—all stars, and a host of lesser luminaries who have given their lives to the cause of human welfare. They are the immortals who have led the way and provided the means for the hundreds of public and private agencies that have carried out details of the program and relieved fear of the scourge of those dreaded diseases which were the nightmare of former generations.

Improvement of public health must be attributed in large measure to the development and application of science in the control of disease through the improvement of our water and food supply, removal of sources of infection, inoculation against disease, quarantine, and improved sanitation. The work has really been accomplished by a limited number of leaders who have been in a position to exercise control over boards of health, health officers, and others who have devoted themselves to human welfare.

Let us examine then the nature of this improvement in health conditions which makes the past fifty years stand out as a period of unprecedented achievement. The first point to be noted is the increased average length of life or life expectancy. This has been raised from approximately thirty-five years in 1880 to sixty years at present; twenty-five years have been added to the average length of life in a little more than half a century. The second point is the expectation of life at the older ages, *i.e.*, at the ages beyond sixty years. According to tables prepared by the Bureau of the Census, persons at the age of sixty-five may still expect to live twelve years; at seventy-five, seven and two-tenths years; and at eighty-five, four years. It is, therefore, apparent that this period is different from all other ages in that its mortality has not improved. As a matter of fact, this period of life has failed to retain the favorable position it occupied in the early part of the century. The greatest decline in mortality has been for the period of infancy. There has also been a marked decrease throughout adolescence and the early productive period. Moreover, the decrease of mortality has proceeded at a lesser rate during middle life, and has disappeared in the later period.

The significance of this situation is fairly obvious. Public-health efforts have been successful for those up to sixty years and unsuccessful for those older. Furthermore, success has been due to the control of those diseases rampant during productive years and not to the control of diseases incident to deterioration attendant upon declining years. The facts of health conditions at the various stages may be a matter of debate. There are those who contend that we are not concerned with the prolongation of life beyond the so-called productive years, but our assumption is that life has its particular value at each stage, and that the improvement of health conditions is equally important whether we are concerned with infancy or senescence, and this discussion is based upon that assumption. We will leave to the theorists the discussion of the relative social importance of the various ages.

Our purpose, therefore, is to indicate the reason for the success and failure of public-health efforts, and the part that education has played on the one hand and its particular problem on the other. We have already stated in part the reasons for improved health conditions in early life and the control of those factors responsible for communicable disease. These measures consist mainly in the provision for an adequate uncontaminated water supply; inoculation against diseases that may be controlled in this manner; safeguarding the food supply; improved housing conditions and sanitation; proper disposal of garbage; and, finally, segregation of active cases of tuberculosis. These various health measures have by no means been adequate. In many instances we still find conditions quite primitive. The problem at present is that of applying measures that have proved effective.

The failure of the health movement in the latter period of life is due to the fact that public-health measures have little or no application. Diseases common to later life result from organic deterioration caused by the mode of living. They are the result of maladjustment to a complex civilization. The strain and pressure of modern life, new problems of food selection and diet, and inadequate exercise and recreation all create situations which the individual has not learned to meet either through direct experience or through formal education. The problem of these deteriorative diseases is entirely different from that of communicable disease. In its vital aspect, the problem is one of individual hygiene, not merely for the declining years but for the whole of life, in contrast with communicable disease, which is a community problem. I am quite aware that all problems of health are, in a sense, community problems but the solution of one type may be found in community action, of the other in personal living. Both are problems of education, but in entirely different senses.

This preliminary discussion seems necessary to lead to our real problem; namely, the place of the school program in health im-

provement. The beginning of the health program in schools dates back to the nineteenth century and was introduced through the influence of the Woman's Christian Temperance Union, itself concerned with the elimination of alcohol consumption. The procedure generally was to secure legislation requiring instruction in physiology, anatomy, and hygiene with special emphasis upon the evil effects of alcohol consumption. The program consisted mainly in learning facts inappropriate to the needs of children, and about the effects of alcohol on the human system, which, however, did not accord with science. The most significant thing about this early program is that it was a beginning of what later became the health program in the schools.

The failure to accomplish its avowed purposes led, toward the end of the century, to a more fundamental consideration of the whole problem of health needs. With investigations by Dr. Smedley on the health needs of school children in the city of Chicago, and his report to the Board of Education, we entered upon a new era of school health development; namely, the introduction of the doctor and later the school nurse. These, however, were concerned with disease and its elimination rather than with a constructive program of positive health development, while the instruction of children continued along lines of the original emphasis. Early in the twentieth century the child-study movement in education appeared in the ascendancy and educators thought they had discovered a new approach to education and a new emphasis in health instruction. They approached the problem indirectly by stories of health, leaving out all formal matter relating to physiology, anatomy, and hygiene. While this emphasis did not improve the specific health instruction, it rendered a more significant service by calling attention to the fact that health has to do with behavior and not the memorization of facts unrelated to children's needs. Thus a forward step was taken in the school health movement.

While this movement was under way the World War broke, with

its astonishing display of inadequate health instruction. Physical defects and weaknesses, which might have been prevented by an adequate school program, were obvious. New private health organizations appeared and older societies became interested in child-health programs. We had new plans for health instruction *ad nauseum*. The "Health Crusaders," the health fairy Cho-Cho, and the health clown were imposed upon the schools because educators had no program and were compelled by the astonishing revelations to do something about health. The inadequacy of the various programs proposed was clear to educators. Attempts were made to examine the whole problem of health in the schools from the point of view of the prevailing educational philosophy and the current needs so far as they had been discovered. This represents the beginning of the contemporary movement in school health.

The first of these fundamental attempts to provide an adequate health program was undertaken under the auspices of the Junior Red Cross which published its results in 1921. The following statement from the author's preface¹ explains the nature of the program.

This book is the second in a series which has for its purpose the organization of the subject matter of the curriculum with reference to specific social objectives. The first book of the series outlined a program of Education in Accident Prevention. This book attempts upon a much larger scale the presentation of a program in Health Education that will make the development of health habits, practices, and knowledge ideals and attitudes a matter of school routine. It does not anticipate the addition of a school subject nor does it leave the development of health to the branch of physical education and hygiene.

A plan is outlined through which each subject of the curriculum may contribute its appropriate part to the development of individual and social practices essential to healthful living. The plan of this series is a new departure in educational practice, but one entirely in harmony with educational theory. This series is a contribution to present educational development by people who are working in practical and theoretical fields and who are attempting to make education serve more effectively the needs of life.

¹ See E. George Payne, *Education in Health* (New York: Lyons and Carnahan, 1921), page 5.

In so far as the fundamental nature of the program of health instruction is concerned, this experiment represents the point of view of the health program as it appears in the schools today.

Since 1921 much thought has been given to the construction of health curricula and the determination of best health practices. Thus has developed a course of health instruction covering the school life of the child through the elementary and secondary schools. These programs take into account the interests, the psychological nature of the child, and his stage of development on the one hand, and the scientific material related to health practices—diet, exercise, recreation, sleep, etc.—on the other. It fails, however, to consider the necessity of discovering backgrounds of the group with which the instruction is concerned. In this particular lies the weakness of the health program in American education today.

The point of view emphasized here may be illustrated by any of the modern courses of study in health in any of our cities or States. One of the best of these published courses is that now in operation in the New York City schools. It covers the entire period of public education and takes into full account the biological and psychological nature of the child with his developing interests and abilities. Moreover, it incorporates within the program the scientific knowledge basic to human living in the twentieth century. Such a course of study would appear to represent the last word in the construction of a program for the education of children in the art of healthful living.

There is, however, a fundamental weakness in such a program, for in its operation it does not take into account the widely differing backgrounds and varying health needs. The difficulty lies in the fact that no program for a city such as New York, or any area, can make proper emphasis for all children in the area. The studies of mortality and morbidity in the Belleville-Yorkville and the Harlem districts display problems of health needs not evident elsewhere. A common program with similar emphasis is unwarranted and will

inevitably fail to meet the specific needs of the children in any particular area. The method of approach is wrong. Health depends upon proper living and a solution consists in the reconstruction of the habits, knowledges, and attitudes of a given group, school, or class with which education is concerned. Instruction hinges upon a definite knowledge of the health conditions and practices of the children and involves an adequate survey of their background. A survey is indispensable to any intelligent procedure in any school district or class.

Furthermore, as the specific health needs are discovered, the program of instruction must concern itself with the health practices of the adult population as well as with those of the children. We have long since realized that small progress will be made in changing the ways of living of children where no changes are made in their homes. Unchanged practices in the home will undo any effort on the part of the schools to effect better living practices in a community. This point of view conforms to what we have learned from the vast achievements in the improvement of healthful living in various parts of the world.

A single example of procedure is that of Rockefeller Foundation in the eradication and control of hookworm disease. In this instance no work was attempted until a survey displayed in every detail the causes of the infection in the particular area with which the program was concerned. There always followed a program of education that would effect a removal or control of the causes of the disease. Such has been the method, moreover, by which health conditions have been improved in the control of malaria, typhoid, infant ills, and other communicable diseases, and affords the basis of a plan essential to the improvement of health. It is amazing that with these concrete examples before them educators still approach the problem of health with a nineteenth-century technique and program, seemingly unconscious of what has been done and the methods by which it has been accomplished.

ALCOHOL IN THE HUMAN MACHINE

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In a nonfiction best seller the author states that the reason we know so little about ourselves is because under the natural conditions of life the human machine works satisfactorily. It was only consideration for others, a desire to relieve physical and mental suffering, that has led to the study of the normal as well as the diseased body. A modern poet has written some lines in merry mood which point out the inconsistency of our concern for the machines we buy, and our carefree ignorance of the mechanism of our own bodies. At the first "queer" noise, the machine is taken to a skillful garage-man to find the trouble. But for a headache or a pain elsewhere, we follow traditional or imitative behavior rather than be governed by independent thought and decisions based upon consideration of facts. This dependence upon what "they say" is largely responsible for the lack of understanding of the relation of alcoholic drinks to individual health and public welfare.

Dr. Haven Emerson says, "The actual and potential damage to human health from alcohol in the United States is greater than can be justly charged to any other commonly used drug substance, or to all of the so-called narcotic drugs combined, as they are availed of by the laity today." "But," say Mr., Mrs., and Miss Public, "alcohol gives energy for work, for play—it 'peps' you up for a good time." "And it's liquid food," adds young Bob, while Mrs. Public, recalling the many and various attractive advertisements, sums up, "It really is good for whatever is the matter with one."

Suppose, before downing their next cocktails, the Public family would devote independent thought to those cocktails, the base of which is gin or rye or bitters of high alcoholic content. If served in the proper cocktail glass containing one-half gill of liquid, each will contain much more than one-half ounce of absolute alcohol.

That is, two such cocktails would contain more alcohol than one large whiskey, much more than a pint of beer, and more than a half pint of claret. A brief consideration reminds one that that same alcohol (1) when applied to a grass stain or a grease spot will cause it to dissolve and disappear; (2) if spilled on the table top will remove the varnish; (3) when used in the laboratory will preserve specimens by absorbing the moisture from the tissues, so they will not decay. During the last fifty years this same ethyl alcohol has become indispensable in the chemical laboratory, where its uses are second only to water because it will dissolve what water will not, and because alcohol's affinity for water is so great that it absorbs water from substances containing it. So many and varied are the uses of alcohol because of these two actions that the story of its manufacture and application to thousands of utilities that enter into the fabric of commercial and social life is one of the great romances of modern industry.

But traditional and imitative emotional and social patterns displace independent thought when alcohol appears in beer, cocktails, or highballs to be taken into the human organism, where it comes into contact with delicate living tissue, a large part of which is water. When a hostess urged another cocktail upon a guest who turned to pour it into a flower pot beside him, the lady cried, "Don't put it there; it will kill the plant." "Queer," he mused, "but she wants me to drink it."

This effect is described by various figures of speech: Thomas A. Edison compared it to "sand in the engine"; a professional writer says it is like "putting salt sea water into the ship's boiler"; Dr. Charles Mayo told Hi-Y boys, "You can get along in the world with a wooden leg, but not with a wooden head." The effects of "too much" drink are known, but why these effects are caused is understood by comparatively few.

One must have first a mental picture that as a city is composed of houses in which active persons live, who perform all the varied duties and activities of community life, so the body is comprised of

organs composed of living particles. The body is the sum of its organs, made up of living cells, as the city is the sum of all the buildings which contain the living personalities.

All cells are fundamentally the same: (1) a thickly fluid substance very like egg white, called protoplasm (Greek, first-form); (2) embedded in this protoplasm is a firmer protein substance, the nucleus; (3) the nucleus and the surrounding protoplasm are enclosed with a covering, the cell membrane. The substances which make up the cell are those which we take in our food: albumen, protein; sugar material called carbohydrates; fat; water; salts; oxygen. Each cell is a bit of living matter which contracts, expands, absorbs food, and throws off waste.

Special emphasis must be placed on the fluid condition of the cells, for it is in that state that an easy movement of the cell molecules is possible, which promotes the constant change taking place in the building up and the breaking down. This constant change is called metabolism and is the difference between a living and a lifeless organism. When these actions cease, the body dies. The three parts of the cell have substances in common—water, oxygen, fatty or waxlike substances named lipoids (Greek: fatlike).

Alcohol taken in any drink passes quickly into the bloodstream. It is not acted upon by the digestive juices, but within a very few minutes of drinking, some is found in the blood, and within fifteen minutes its presence there has been detected by the effect on the nerves. The circulation bathes every cell almost two times a minute, carrying to it water, food, and oxygen, and collecting the wastes. Alcohol, carried directly to the cells, comes in contact with the lipoids in the cell membrane, the solution or disturbance of which admits the alcohol to the interior.

Scientific research has so far failed to determine just how alcohol interferes with cell activity, but there are at least four theories:

1. The dehydrating action on the protoplasm slows the process, due to loss of some of the precious water.
2. Lipoid is readily soluble in alcohol, a well-known property of

a number of materials, which benumb the nervous system. The disturbance of this substance lowers the activity of the molecules, causing a condition known as narcosis.

3. The salt fluids of the body are generators of fine currents of electricity. While water is a conductor, alcohol is a nonconductor.

4. Alcohol interferes with the oxygen needs of the cell. The accumulation of waste slows down cell activity, as ashes in the furnace interfere with proper performance. Such accumulation leads to fatigue, which finally results in exhaustion.

These four theories deal with four different substances—water, fat, electricity, oxygen. The one thing scientific investigation has shown is that alcohol in the blood creates definite disorder in a number of conditions necessary to cell activity.

Referring to the figures of speech used by Edison, Bastedo, Mayo: "Sand in the engine" may not stop the machinery, but will interfere with its running power, gradually injure the bearings, and finally secure a place in the junk heap; salt sea water in the ship's boiler may produce steam in an emergency but will eventually corrode the metal and produce an explosion; a "wooden" head may cause the whole human machine to run amuck because of lack of judgment. But what may alcohol do in the human machine during the minutes, months, or years which intervene before the junk heap, the explosion, or the final crash?

A comprehensive statement is made by a specialist in the symptoms, causes, and nature of diseases: "No other poison causes so many deaths, or leads to or intensifies so many diseases, both mental and physical, as does alcohol in the various forms in which it is taken." Medical writers class alcohol as one of four health scourges of civilization, the other three being cancer, tuberculosis, and venereal disease. Social workers say alcohol "makes the bed for tuberculosis"; studies show it is closely related to venereal infection; it is the sole cause of alcoholism, which does not mean drunkenness, but the effects upon users who may never have been drunk, but whose deaths resulted from alcohol.

Since the anatomically highest and last developed parts of the brain are weakened and suspended first, the functions of these parts are affected first and by a small amount in the blood. We shall consider the relation of alcohol to mental and physical health in this order, from the above downward, and from smaller to greater amounts.

Health is defined as a state of being whole in body, mind, and soul—free from pain or disease. The word disease is significant; the normal adult in perfect condition is at ease with a temperature at 98.6 degrees. If the temperature varies by so much as one-half degree—up to 99, “feverish”; down to 98, “chilly”—it is indication of some disease, a symptom something somewhere is wrong. This unnatural “feeling” is comparable to the “queer” noise in a mechanical engine.

Chemical analyses show that because the brain cells are especially rich in fatty substances it takes up larger amounts of alcohol, ether, and chloroform. Also, brain cells are as much as eighty per cent water. Recalling the action of alcohol on fats and its affinity for water, one sees why the drinker’s head machinery is out of order (thinking) before his feet machinery (staggering).

Man’s behavior, unlike the lower animal’s, is not governed by instinct which, as a matter of protection, prevents it from eating or drinking anything strange. Man’s power of judgment and self-control are given to protect him from unlimited indulgence, imitation, ambition, or originality. The action of small amounts of alcohol upon these highly organized cells impairs first the inhibitions—the power to “hold in.” With these controls impaired, the behavior is left to the direction of animal emotions and impulses, but without the control of instincts provided for protection. The condition of the human machine is like that of the auto on the highway when the driver at the wheel suffers heart failure; both machines are operating without intelligence. In 1936, there were 38,500 fatal highway accidents with at least one million persons injured. A study made in 1935 showed that in 60 per cent of the fatal cases

a glass or two of beer had been drunk an hour before, and then—sudden death.

Just now the country is in the midst of a campaign to stamp out venereal disease. The number of persons infected is variously estimated from one to seven million. But it is known from those victims who seek medical treatment that from 76 to 90 per cent became infected after a glass or two, when judgment and caution were impaired and the sex impulse controlled behavior.

The British Minister of Health in 1926 said, "If we are to rear and maintain a healthy race, we must first deal with alcoholism, venereal disease, and mental deficiency. Alcohol is the ally and handmaiden of venereal disease. The two go hand in hand. When alcohol is wedded to venereal disease the offspring is feeble-mindedness."

The continued use of small amounts—as in two bottles of beer, a couple of cocktails, or a highball—tends to the use of amounts increasing both in size and frequency, for alcohol like other narcotics creates a craving for itself. As the body builds up a protection, the drinker finds the amounts heretofore taken do not bring the feeling of carelessness and general well-being, and the habit of taking more is formed. "But," says the Beginning Drinker, "I feel so much better, so rested, so ready for anything." The error is in that word "feel": the drinker feels, not better, but *less* of whatever sensation was uppermost—and for the time being is an altered individual in an unreal world, for all the senses render inaccurate reports. The mind temporarily lacks its normal factor of judgment and conspicuous elements of its self-control.

"But," argues the beginner, "is it not worth-while at the end of the workday to shed the reality of care and weariness and enter into the unreality for rest and change?" If it were not for those two actions of alcohol, that might be so. But these actions leave permanent effects upon the cell structure. In the body cells the injured tissue is replaced by connective scar tissue, but injured brain cells are not so repaired.

After the nervous system, the cells of the digestive organs are most susceptible. The use of rubbing alcohol to harden the skin to prevent bedsores is common knowledge. It may be said that alcohol in a glass of beer or a cocktail gives the digestive tract an "alcohol bath." The action of alcohol upon the mucus of the mouth, gullet, stomach, liver, pancreas, kidneys, walls of blood vessels, the plasma and blood corpuscles is always the same, in direct relation to the amount of alcohol in the circulation. A little alcohol is a little injury; *more* alcohol is *more* injury; MUCH alcohol is MUCH injury, but no alcohol is no injury.

"But," say the Public Family, "wines and cocktails aid digestion." Sorry, friends, but no test observed in animals or humans has shown that alcohol speeded up the digestive process. The numbing of the nerves prevents any *feeling* of discomfort.

Since alcohol causes no particular disease but affects the organ with cells least resistant to its action, the results of drinking are many and varied. The action is always the same but the manifestations are different; conditions develop not unlike those caused by "sand in the engine" or sea water in the ship's boiler. When the Creator gave to man this human machine, so wonderfully and marvelously made that it anticipates every possible need, to be directed and controlled not by instinct, so that it *cannot* go wrong, but by intelligence, to adjust itself continually to new and ever-changing conditions, He endowed it at every point with powers of self-protection, to repair injury, and of recovery to a very great degree.

Perhaps the most marvelous of these are the white blood corpuscles, the enemies of body enemies. But these protectors themselves are susceptible to alcohol, and thus the drinker is more susceptible to infections than the nondrinker, allowing germs to multiply in the system, and at the same time retarding or preventing recovery from accidents, wounds, chronic and acute diseases. The best proof of this is in the tables of insurance companies whose business it is from a purely commercial standpoint to know which are the persons on whom they may place money. Their records exclude heavy

drinkers. We find three groups recognized: (1) those who said they took not more than two glasses of beer or one whisky a day at time of insurance; (2) those who had been drinkers to any degree but were not drinking at time of insurance; (3) more than those who said they took more than two glasses of beer or one of whisky a day but regarded as *temperate*. Placing the average death rate among all insured lives at 100, we find group one had 118 deaths, nearly one fifth more than average; group two had 165 deaths, one half more than average; group three had 186 deaths, nearly double the average. "But," says Bob Public, "look at Mr. X; he lived to be ninety-nine years old and he drank whisky all his life." Well, do you remember if he ever did anything else? Now, recall men who drank moderately and died suddenly in their forties from pneumonia, an operation, heart condition. Reread the statements by Dr. Emerson and Dr. Bogen. Dr. Emerson adds to what he says about human health, "Alcohol causes a considerable number of deaths, about twice as many as are reported as due to alcohol." A conclusion cannot be formed from one instance.

"Well!" cry Mr. and Mrs. Public, "then why do people drink?" There are several obvious reasons: (1) because other people do; (2) because other people ask them to; (3) because of the opportunities; (4) because of attractive advertising.

"But," says Mrs. Public, "those are not good reasons for lowering one's resistance to infection, delaying recovery from disease and accident, and shortening life expectancy and even impairing bodily and mental activity. Why, if people *knew*—." Yes, Mrs. Public, that is just the reason. People do not know what alcohol is and does. Many will not believe there is alcohol in beer and wine. They do not know its action on the higher functions of the brain; they despise those drinkers as "weak" who continue to drink after it becomes evident that drink is injuring them mentally and physically. "Look at me," they say, "I can drink or let it alone." When we do look at them, we see that they always drink, and never, or seldom, let it alone.

"Look at me," says another, "I drink only now and then." If we look, we discover they drink more *now* than they did then. "Then," say Bob and Miss Public, "we should not drink at all. But how can we refuse without offending our hostess?" Emily Post says, "Smile and say, 'No, thank you,' or 'I do not take it.' " In a short time your friends will provide for you the equally colorful orange or tomato juice. If there is a tendency to "razz" your stand, you may want to quote the young college man, "I haven't any more brains than I need, and I want to keep all I have."

What is the relation of alcohol to the human machine? Edison coined a good figure of speech! It is indeed like sand in the engine.

HEALTH EDUCATION AMONG NEGROES

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Health may be defined as the quality of life that renders the individual fit to live most and serve best.¹ Its principle involves keeping the body and mind at the highest levels in order to give and take the best that life has to offer. Generally speaking, a sanitary system of living is the first and most important prerequisite for good health.

Studies in health problems of the Negro should involve a consideration of the social and geographic conditions under which he lives. Poverty, poor housing, lack of medical care, along with prejudice and ignorance, account in a large measure for the health plight of the Negro. It is a well-known fact that the great mass of the Negro population is still concentrated in the rural sections of the South where even the barest necessities are extremely difficult for him to obtain.

HEALTH PROBLEMS OF THE NEGRO

The special health problems of the Negro are found in cases of tuberculosis, venereal diseases, and infant mortality. The causes of most of these diseases may be traced back to either ignorance or poverty. Careful investigations and intensive study have exploded the one-time theory that the Negro race is essentially a physically weak one. A statistician of the Metropolitan Life Insurance Company has concluded that:

The Negro death rates for practically all diseases in the prevention or cure of which care and sanitation are of paramount importance are much higher than among the whites, but this does not prove that the Negroes

¹ J. F. Williams, *Personal Hygiene Applied* (Philadelphia: W. B. Saunders and Company, 1926), page 18.

are inherently more susceptible to such diseases. It is probable that their high death rate is due more than anything else to poverty and lack of medical care.²

Many other research problems have revealed similar facts. The work that has already been done in the field of health education for Negroes is invaluable and cannot be overestimated. If the health status of the Negro could be raised to the same level as that of the white race one of the major race problems would be solved. But in order that such a possibility may become a reality the social and economic standards of the Negro must be greatly improved.

Perhaps the best index we have of the health status of any race is the infant mortality rate. It has been ascertained for many years that the infant mortality rate of Negro children is excessively high when compared with that of the whites. No doubt this high rate can be directly attributed to the illiteracy of the parent, the lack of prenatal and postnatal care, and the absence of proper medical care during the crucial stage of pregnancy. According to reports of State departments of health in the Southern States:

Fewer than one third of the Negro births are attended by physicians, the other two thirds or more being attended by midwives or have no attendance.³

As long as such conditions continue to exist, just so long will the infant mortality rate of the Negro race remain excessively high. Health education is the only solution to such a problem as this. Parents must be taught the importance of prenatal and postnatal care. They must be shown the fallacy of the superstitious belief that it is good luck to be attended by a midwife during pregnancy. Even in sections where clinics are available proper medical advice is often disregarded because of this belief.

² Louis I. Dublin, "The Health of the Negro," *Annals of the American Academy of Political and Social Science*, vol. 140 (November 1928), pages 77-84.

³ *Child Health Problems* (Nashville: Julius Rosenwald Fund, 1924).

The tuberculosis death rate is another indication of the health status of the Negro. It is a known fact that tuberculosis is a disease that attacks the impoverished classes of society. Figures in 1930 showed that the tuberculosis death rate of Negro children in the lower elementary grades was five times higher than that of the white group. From the ages of 10 to 14 they reached the alarming proportion of nine times greater than the whites of this same group. Of great significance was the fact that Negro girls of college age in 1930 exhibited the highest rate on record, 398.1. The rate of Negro girls of junior-high-school age was greater than that of the boys in the same category.⁴

In 1928 Dr. Eldridge of the Tennessee Department of Health reported that the death rate from tuberculosis among Negro children in that State was ten times greater than that of the whites. The rate of 270.3 was most unfavorable when compared with the rate of 94.4 for whites.⁵ Since that time, however, a program has been in progress to correct this high differential in this State. This is true not only in the State of Tennessee but other States as well. It is necessary for the welfare of the nation that this high tuberculosis death rate among Negroes should be checked, because it is a menace not only to the Negro whom it ravishes but also to the whites who must dwell in its presence. Negroes who are employed by white families and otherwise transmit the disease to the whites. It has been estimated that about twenty-five per cent of all tuberculosis deaths in the United States occur among Negroes.

Venereal disease is a third cause of the high death rate among Negroes, and whites as well. One reviewer of social diseases says that:

In the United States there are well over a half million new cases of syphilis and over one million new cases of gonorrhea annually. These figures are a challenge to every one, both as to cause and prevention.

⁴ *Child Health Problems.*

⁵ *Ibid.*

. . . Up to 1928 there had appeared in the literature a large number of guesses and personal impressions as to the incidence of venereal diseases, but more especially of syphilis, in the Negro. . . . The conservative conclusions were that syphilis was from one and one half to three times more frequent among Negroes than among whites.⁶

These social diseases are transferable mainly through sexual intercourse; and the most likely reason why more Negroes die from them than whites is that the latter seek medical care in the early stages of the disease more often than do the Negroes. In many instances insufficient income is the reason for this lack of medical care; in others, ignorance. Sometimes the disease reaches a chronic state before the person is aware of the fact that he is affected.

Health education alone can greatly change but it cannot greatly lower the high death rate among Negroes which is caused by these diseases. The low economic status of the Negro race in general must now and always be recognized as a handicap to its health conditions. However, for those who are financially able to follow its teachings, health education is a sure means of salvation.

THE FAMILY

In order to get at the root of the health problems of the Negro it is necessary to consider carefully the home. In the first place, overcrowded housing conditions are lamentable. If the Negroes live in the rural sections of the South, and the majority of them do, they live in shacks with no sanitary accommodations whatever. Their diet consists mostly of salt pork, corn bread, and syrup or sorghum. Vegetables are seldom eaten. Milk is sometimes used but only a few have cows. Many of the houses are built without windows, with no supply of water near by, and no provisions for bathing or light. Such dwellings make a dreary, unhealthy setting for children. The overcrowded conditions leave no room for privacy

⁶ H. H. Hazen, "A Leading Cause of Death Among Negroes," *The Journal of Negro Education*, VI: 3, 1937.

or pride or any sense of honor. Morals are almost unknown; therefore the unmarried mother is a common spectacle. For the most part midwives are employed at childbirth, rendering unscientific medical care that is the cause of many unhealthy, deformed children.

The absence of adequate medical and health services to Negro families may be attributed to an utter lack of proper education to see and appreciate such services, and the low economic status of Negro communities, particularly the farm districts which offer no inducement to the private practitioner to spend his time in caring for the underprivileged. As a result, there is insufficient coöperation from medical men, nurses, and health and social workers who should bring the knowledge of health and good living to these communities. Until we set up a program for the expansion of medical services to these backward sections, the help which they should obtain will always be lacking.

When the Negro leaves the rural sections of the South and migrates to the North he is still faced with the problem of housing his family. Because he is unable to earn anything but a low wage he is forced to live in overcrowded sections where rent is cheap. If the house seems roomy the family is more than apt to take in boarders in order to increase the income. Children have no yards in which to play and enjoy the healthy outdoor exercise that is so necessary for their proper development. Morality has no better chance here than in the one-room cabin in the South.

The health program for Negroes calls for protection against all forms of transmittable diseases for all members of the family. It is practical and wise to expend the means for this protection. Sanitation, medical care, public-health services, slum clearance, adequate educational facilities, economic and social welfare, a positive planning for the control of venereal diseases, the liquidation of prostitution will all assist immeasurably in the improvement of health conditions of Negro families.

PUBLIC SCHOOLS

The legislatures of the Southern States have passed laws or acts providing for health and physical education of pupils in the common State and other public schools. These laws are aimed to secure coöperation between the education and health authorities of the State and usually describe the methods to be used in carrying these provisions into effect. A study of these reveals that general objectives of health education as prescribed for the common schools in the Southern States consist of the following:

1. Protection of the individual and community health
2. Promotion of the health and physical fitness of the individual
3. To safeguard not only the individual's physical fitness but that of his associates as well
4. To develop the health of the individual so that his physical and mental abilities may be used to the best advantage
5. To teach the reasons for ventilation, proper heating and lighting, sanitation, and for physical instruction
6. To develop right tastes and sound judgment in such matters as food, clothing, shelter, and exercise
7. To make health practices habitual

Numerous methods and devices are to be used in order to obtain the best results from the program of health instruction. Projects, songs, dramatizations, poster making, charts, games, health plays, health scrapbooks, health clubs, socialized recitations, health bulletins, experiments, field work, and the question box are some of the many devices recommended by the departments of education in bringing knowledge of health and healthful living to the students and parents.

A study of the prospectus of some departments revealed correlations with such subjects as art, geography, history, citizenship, spelling, manual training, agriculture, and penmanship. Some departments have established well-organized means of measuring the results of health teaching. Thus, we notice the recommended use

of standardized tests, health records, score cards, vegetable charts, etc. To a large extent the work of health and physical education in the public schools may be divided into three aspects and each attacked from these viewpoints:

1. Physiological health, which attempts to control proper growth in height, weight, structural and functional development, and which strives for the efficiency of muscular, nervous, mental, emotional, glandular, nutritional, circulatory, respiratory, and reproductive functions
2. Mental health, which seeks to develop the right emotional qualities, such as happiness, cheer, courage
3. Social health, which attempts to instill a new attitude in informing students accurately and scientifically about the facts of human life and human relationships

It may be seen from this survey that the physical-education and health-education programs are well conceived and thoroughly planned. The States have not failed in formulating a clearly defined plan of health education. The failure lies rather in the development of agents, agencies, and means necessary to put these well-conceived ideas into effect. Dr. Paul R. Mort⁷ shows that for the year 1930 there was an average expenditure per pupil of \$32.42 in eleven Southern States, but if considered racially, the average expenditure per pupil for whites is \$44.31, while for Negroes it is only \$12.57. In South Carolina the per capita expenditure for white children for the period 1900 to 1930 was four times that for Negroes.

These inequalities in the distribution of school funds may also be observed in the expenditure for schoolteachers' salaries. From Dr. Mort's study we also learn that in 1930 the annual average salary paid Negro teachers was \$423.00, while the whites received \$901.00. It may be further observed that the amount of money invested in school property in fifteen Southern States was \$1,086,842,000, or \$123.00 per pupil enrolled. While the average invest-

⁷ Paul R. Mort, *State Support for Public Education*, United States Office of Education.

ment in plants and equipment for each white pupil was \$157.00, for the Negro pupil it stood as low as \$37.00.^{*} With such meager opportunities it is no wonder that we find the agencies unable to carry forward any well-conceived plan.

The Negro public schools in the South are hopelessly and inadequately equipped. Like the homes, the school buildings are usually too small and overcrowded. Ventilation is very poor for the most part, and there are seldom any provisions for hot lunches at noon. Most of the public-school buildings are dirty and the grounds uncultivated. There are usually no locker rooms or any sanitary place for wraps to be kept. With such conditions it can readily be seen that the schools have no means of executing a program of health education. Into such schools come hundreds of children, poor and wretched, seeking enlightenment in this the only place where they may find it. Many do not even realize that they are being deprived of the rights of citizenship when they enter these public schools which make no provision for health education, although both health and physical education are a recognized part of the curriculum offerings approved by the State for both white and Negro schools.

In many municipalities new, sanitary school buildings have been constructed, but lack of funds has prevented the completion of most of them. Notable examples of such conditions are to be found in many of the large urban centers where excessive overcrowding has led to unsanitary health conditions which seriously impair the health and moral standards of the students. In many instances rooms which were designed for sanitary accommodations have been utilized for classrooms, and the lack of janitorial services sufficient to keep the buildings clean and sanitary has been felt.

A definite program of health education for Negro public schools must involve more than the provision for such in the curriculum. In the matter of health education the laws themselves are of no

^{*} *State Support for Public Education.*

value unless they are put into execution, and until such time Negro communities will continue to present the highest morbidity and mortality rates.

COLLEGES

In *The Journal of Negro Education* for July 1937, Professor Paul B. Cornely of Howard University shows that little hope for health education might be expected for students who graduate from public schools and enter Negro colleges. His study reveals the fact that health education in the Negro college is in a deplorable condition. Confusion in administration, inadequacy of personnel, equipment, and procedure are noted in the teaching of hygiene, sanitary supervision, and health services. His facts forcefully show that health services are inadequate both in extent and scope. He attributes these inadequacies to one or all of the following factors.

1. The apparent lethargy of many college presidents in matters pertaining to the health of their students
2. The lack of an adequately trained personnel
3. The lack of coördination of available facilities

A soundly constructed and well-executed program of health education in every Negro college would be invaluable to the Negro race. Because graduates of these institutions constitute an influential group, if they are made health conscious it may be assumed that they will in turn influence their families and the communities where they will be employed as instructors.*

CONCLUSION

If for reasons that have been presented and discussed here the Negro cannot obtain training in the ways of healthful and sanitary living in neither his home, the public school, nor the college, wherein lies his hope for decreasing his mortality rate? It is true that there

* Paul B. Cornely, "Health Education Programs in Negro Colleges," *The Journal of Negro Education*, VI, 3, 1937.

are some social agencies that are adequately equipped to render public health services to the Negro, but for the most part these agencies are located in the north and eastern sections of the United States and not in the South where they are most needed and could do the greatest service. The same is true of clinics and hospitals.

Health education among Negroes is a very necessary and important factor in their development. No man can render his best service to humanity if he is infected with disease, and no man can ward off disease unless he is properly fed, clothed, and sheltered. One authority has truly said:

The problems of the Negro are not his alone. They belong to the whole population. There is no possibility of isolating either the Negro or his diseases.¹⁰

In view of this fact the problem of health education among Negroes is the problem of a nation of which this race is only a part.

The National Conference on Fundamental Problems in Negro Education, held in Washington in 1934, summarized the need of health education among Negroes as follows:

1. A conscious awakening on the part of Negroes themselves to the need for correct health habits
2. The clearance of slum sections in cities and malaria-infested districts in rural areas
3. An equitable share of financial support and service in health problems
4. Effective health education, with emphasis on health habits to be taught in every school
5. The provision for more modern schoolhouses with adequate financial support and service in health problems
6. The provision for integrated health courses compulsory for all teachers
7. Facilities for the training of nurses and internes and for the treatment of Negro patients

¹⁰ Ray L. Wilbur, "The Health Status and Health Education Among Negroes in the United States: A Critical Summary," *The Journal of Negro Education*, VI, 3, 1937.

8. The employment of more Negro doctors and public-health nurses on official staffs of schools, counties, and cities

9. Continued experiments and demonstrations in control and prevention of communicable diseases

10. The functional coördination of official and nonofficial agencies—nation, State, and local—in projecting intensive and extensive programs for the well-being of Negro children

The adequacy of such well-formulated plans cannot fail to be recognized. If these theories were put into constant practice the results would be an inevitable lowering of the death rate among Negroes. This would lead to a practical emancipation in each sanitary area of this social democracy, embracing all races and classes of the population in its welfare program. The problem of race adjustment by health education is not sectional, for the Negro is associated with other races. The problem of health education among Negroes is like all of his problems: it is fundamentally an interracial question and must be recognized by both races if all elements of the population are to be brought up to the American norm.

THE NURSE EXAMINES THE SCHOOL HEALTH PROGRAM IN ITS SOCIAL SETTING

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The cultural level of a society can be measured by the provisions it makes for the health and welfare of its children. If the children in a social group are neglected or abused or if they are required to begin work as soon as they have the strength and ability to do so, such a society is regarded by most observers as low in the scale of cultural development. A society, on the other hand, which sets a high value on children and places their physical and mental development among its first objectives would be considered by most students as having attained an advanced stage on the cultural scale. We of the present generation condemn those societies of the past which permitted children to do drudgery in factories and mines, as future generations will undoubtedly condemn those of our contemporary societies which exploit the bodies and minds of their children. An enlightened society will recognize in each of its child members a growing, changing, and developing individual, whose right to an opportunity for these dynamic processes to unfold to their maximum extent and variety must be fully guaranteed. Such a society will understand that its own growth and stability are synonymous with the growth and development of its young members. It will also realize that the curbing of individual growth or the setting up of artificial limits to the development of the individual is the direct path to social decay and extinction. The developing human personality is the most powerful force ever evolved. No society or social order which thwarts or retards the onward thrust of this force can long endure. Wise social leaders, discerning the direction which this force is taking, fashion and guide their social programs accordingly.

Two concepts should permeate the thinking of the student who is concerned with the health problems of childhood and youth. The first of these concepts is *variability*. While nearly every person accepts the truth of the statement that there are no two individuals exactly alike, few students of social problems are fully aware of the implications of this statement. The recognition of variability means that the variety which is encountered among the individuals in a social group should characterize every phase of the life of the social group: educational objectives and procedures; emotional and personality development; physical health, development, and welfare; vocational adjustment and preparation; ultimate social participation and responsibility. Unfortunately, it is easier to recognize individual differences or variability in words than in practice. As a result, our actual educational and social programs lag far behind our educational and social thinking. It must be conceded, however, that to an increasing extent social programs are embodying the principle of variability.

The second concept which the student should keep in mind is the fact that *the individual grows and develops in a social medium*. This is to say the health problems of childhood and youth with which we are concerned here are not to be regarded as problems of the individual child or youth, to be attacked and solved in terms of individual adjustment. These problems concern the social group of which the individual is a member, and they are to be attacked and solved in terms of social readjustment. All the desirable qualities and attributes in children and youths for which parents, teachers, nurses, social workers, physicians, and others are working should be regarded primarily as qualities and attributes of the society of which the children and youths are members. The physical, mental, and social characteristics of a child are the embodiment of the physical, mental, and social characteristics of his social group. Undernourishment, emotional instability, juvenile delinquency, as they appear in individuals, are symptoms of social maladjustments.

GOOD HEALTH AND ATTEMPTS TO MEASURE IT

Because of its obvious importance as the basis for all of life's activities, many attempts have been made to measure good health. By combining measurements of the individual such as height, weight, lung capacity, blood pressure, heart rate, muscular strength and endurance, scores in running, in jumping, and in performing certain athletic feats, a variety of measures of health status or of physical fitness has been developed. Few of these indices of health are in wide or consistent use. While, presumably, it is possible to measure anything that exists, the fact remains that the quantifying of health has proved most elusive. One reason for the present difficulty is that good health is not so much an objective, measurable quantity as it is a subjective, intellectual inference. This characteristic also applies to disease. The particular disease with which a patient is suffering can be determined not by multiplying measurements of the patient and combining them into an index, but by having the patient examined by a competent diagnostician. All of the patient's symptoms are brought together in the mind of the diagnostician as a "syndrome" from which the nature and name of the ailment are inferred. While, of course, maximum use should be made of every sort of measurement available, it seems just to conclude that good health is also a "syndrome" which must be inferred from symptoms of good health by the competent nurse and physician.

SCHOOL HEALTH SERVICES AND PROGRAMS

The phase of social welfare which aims primarily at the improvement of the health of children and youth is the school health program. Is it not remarkable that the school, a social institution begun originally as an agency to give children and youth an education in the intellectual or academic sense, should have come to include within its functions the extensive and varied activities which make up the health program of the present day? This enlargement of the

school's function has gone on step by step with the extension of education to the children of underprivileged families, with the weakening and breakdown of the family under the weight of the economic crisis, and with the rapid strides that science has made in the control and prevention of communicable diseases and in the correction of remediable defects. The fact that the school is a social institution which possesses legal control over the large majority of the children of the community accounts in no small measure for the frequency with which programs of social welfare seek to be introduced into the schools. As the school health program has grown, it has come into conflict with other social institutions upon the vested interests of which it has encroached, notably the family and the family physician. In most considerations of school health services and programs, the point is made repeatedly that these services are designed primarily for the education of the child and of his parents in health, that remediable defects shall be discovered, that the responsibility for the correction of these defects shall be placed upon the parents, and that treatment and curative procedures shall be carried out by the family physician. Such treatment as is given in the school health program is justified as emergency or temporary, with the implication that such treatment will cease as soon as some other provision is made available. There is, however, a steady increase in the number of parents who are unable to afford the medical services necessary for the correction of defects found in their children and who, for the same reason, do not have a family physician. These families, therefore, must choose between doing without medical attention and getting cared for by clinics or other social agencies.

An effective school health program should include the following services: periodic health examinations, preferably by a physician, otherwise children should be inspected by the school nurse or by the classroom teacher and those who show signs of physical defects identified for more detailed attention; daily health inspection of all

pupils and students for the prevention and control of communicable disease; weighing and measuring of all pupils at definite intervals as a basis for identifying any marked departures from normal growth; immunization against smallpox and diphtheria; education in the care of the teeth and the correction of dental defects where such service is not otherwise available; a school lunch, provided at cost, for children who cannot go home for it and for those children who might not otherwise have a satisfactory one; a mental-hygiene program, articulated with the classroom instruction, for the prevention and control of incipient mental deviations and behavior difficulties, and adequate follow-up work among those parents who are known to be financially able to correct the remediable defects found in their children. It is to be assumed that the foregoing services will be accompanied constantly by a continuous program of education for health. The nurse shares with other members of the school personnel responsibility for the educational phase of the health program.

TYPES OF SPECIAL PROBLEMS AND PROVISIONS FOR SOME OF THEM

In addition to the general protection and care that should be given to all children and youth, there is special protection and care that should be given to certain children whose special relationships and problems are exceptional. The children who need special care are the victims of the stresses, strains, and shocks which the family as a social institution must receive in present-day industrial life. It should constantly be borne in mind that our present economic system, similar in many respects to a wild animal on the rampage, drives forward on its relentless way, without regard for the effects of its course upon our social institutions. As a consequence, there is no social institution that does not bear the scars, cracks, weaknesses, and distortions that result from being bumped and trampled upon by our economic system. Often one or both of the parents die while the children are young; frequently the chief wage earner meets with

a crippling or fatal accident; chronic illness reduces the family to destitution; unemployment or irregularity of employment deprives the family of vital necessities; sometimes mental disorders develop which break up the family; sometimes also one of the parents, no longer able to sustain the burden, will desert the home. These and similar eventualities, which shatter and wreck the home, have disastrous consequences for the children affected. It cannot be too frequently reiterated that public-health nurses, social workers, visiting teachers, and others should guard against accepting superficial, ready-made explanations for these social conditions. More specifically, such phases as "unfavorable home conditions," "broken home," "father unemployed," "mother a chronic invalid" should be regarded as effects and not in any sense as causes. The real cause is that explanatory principle which relates all these "misfortunes" and "accidents" into a coherent unity. The alert, courageous worker in the field of child health and welfare should not be content until this principle has been uncovered. While working diligently on individual problems, nurses, social workers, and others should at all times think of these problems in terms of the social system and background which make such work necessary.

HEALTH EDUCATION FOR ADULTS

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In our own community and county with a population of mixed nationalities still clinging to the ancient traditions and customs of their forefathers, there is much to be done in health education. To change the attitudes and ideas of these groups requires slow but thorough organization and instruction. If an interest in a health program could be created among the mothers, by helping them to solve their immediate health problems in the home, there would be no limit to the growth of the program. With this idea in mind the organization of a health program was begun.

The American Red Cross seemed the best qualified organization in the county to furnish the instruction. They were prepared to furnish a textbook with graduate nurses as instructors and a course in Home Hygiene and Care of the Sick, on three levels:

1. The standard course for those capable of preparing the work as outlined in the text
2. A modified course for those with a limited knowledge of English
3. A junior course for boys and girls in grades seven to ten inclusive

These courses are definitely planned to continue over a period of fifteen to eighteen weeks, meeting once each week for a period of two hours. Regular attendance and the successful passing of a written or oral examination entitle the student to a certificate at the completion of the course.

Four years ago the Red Cross, with the assistance of local agencies, began these courses with volunteer instructors and a limited amount of capital. Until the program was absorbed by the adult-education division under the WPA, travelling expenses were too high to permit instructors to wander far from the home office, but the groundwork was well done. Then instructors were paid a sal-

ary, many more were employed, and the program was carried to every part of the county. Over an uninterrupted period of one and a half years there were forty-two classes organized, six nurses employed as instructors, and 973 persons (mostly mothers and expectant mothers) had completed the course and were granted certificates.

These course were not limited to the textbook alone. Field trips were taken to hospitals and clinics; there were house-to-house visitations, including bedside nursing, inspection of homes and tenements; community clean-ups were sponsored; household sanitation in bedrooms, kitchens, bathrooms, and yards were projects of these classes. An outstanding project, of the competitive type, was the preparation of a three-day menu for an expectant mother on a food budget of twelve dollars per week for a family of four, which included two children. One hundred and one mothers participated in this project; competition was keen and results interesting. These field trips and projects created a desire among the students to practise in their homes and communities what they learned in the classroom.

Lincoln House, a community center in the Fifth Ward of our county seat, has attacked the health situation among the one thousand Negro population with much force. The area in which these people live is already overcrowded, the houses and apartments have deteriorated, and the general structural conditions are unsatisfactory. This is reflected in high sickness and death rates. Until the program at Lincoln House, this area was known for its vice operations, with a high percentage of syphilis in both children and adults.

One of the first workers added to the staff was a trained nurse, paid with WPA funds, who assembled the women into classes for health instruction, conducted a clinic in the center, visited and advised mothers, encouraged those in the early stages of syphilis to attend the hospital, distributed literature on various diseases, arranged to show motion pictures to educate the people concerning

their health; in general, the nurse led the way to better health. One of the outstanding features has been the observance of Health Week in April when a united effort is made to clean the homes, yards, alleys, and streets, and to have the families visit their physician, dentist, and optometrist or oculist for examination. This past April a free clinic was held in one of the hospitals which was attended by one hundred twenty-five persons from the area of Lincoln House.

What has been the effect of this program among these people? The nurse reports that there is a remarkable improvement in the general health. There is more syphilis than is wanted, but the encouraging thing is that many have found out that they have the disease and are doing something about it. Persons who otherwise would not, are taking treatments as a result of the persuasion and direction of the nurse and the knowledge they have gained from literature and class instruction. Likewise, the same thing may be said of other diseases; the people are learning what to do even to avoiding and fighting the common cold.

An interesting organization, the Home Hygiene Club, developed in the northern part of the county, composed of those who completed the course in Home Hygiene and Care of the Sick. This group made an investigation into the health needs in that particular area. They found five schools with a total enrollment of 1,495 children without any health or nursing facilities. The group immediately organized and sponsored a health program for these children for the next school term. The program consisted of

1. Measurement of weights and heights of children
2. Administering of toxoid to the first three grades
3. Organization of a well-baby clinic
4. Treatment for the prevention of diphtheria
5. Administering of vision tests to determine those handicapped in schoolwork by defective vision
6. Providing opportunity for older girls, who are considering nursing as a profession, to assist in the program and thus enable them to determine their vocation

The committee in charge is actively engaged in organizing adult classes for the health course. Accurate records are filed and information is collected on every case. In every respect this program has been successful. The foundation of the most extensive health program ever attempted in this area is being completed.

When an eighty-two-year-old woman will walk one mile once per week for five months and not miss a single meeting, when adults become so enthusiastic that they organize new classes of their own accord, when they write letters of praise for the course, telling how they were helped in solving their own personal health problems, there is reason to believe that these people appreciated the opportunity afforded them and that the course of study was well organized and presented. One young woman is employed as a child's nurse after having completed the course in Home Hygiene and Care of the Sick.

A large group in a small isolated community expressed so much enthusiasm for the program that it seemed advisable to organize them into a political club. An application for a charter revealed that the purpose of the club was to promote the civic, educational, and recreational activities of the community. The charter was not granted.

There is no doubt about the success of this health program to date, but what has the future in store for such a splendid beginning? New classes were organized and a few weeks later orders were issued to reduce the number of nurses on the pay rolls of the WPA. Today there is one nurse left on this fine project. Those who were removed from the pay rolls have consented to carry on without pay, at least until the present classes have completed the course. Then what? Unless funds are forthcoming from some source the whole program will stop. This seems to be the outcome of most educational programs financed by WPA funds. Had this program been financed and expanded for one more year under the present leadership, there is every indication that adults would be

willing to pay a small fee for the privilege of attending these classes. The enthusiasm and leadership in the various groups would be the means of establishing a complete health program in the schools, churches, homes, industrial plants, business places, and the community in general.

When people are being taught to help themselves and seem willing to do so, is it not a good policy to have them continue? During the past few years we have debated the problem of socialized medicine in all parts of America. Socialized medicine may have a place in society, but a spontaneous, growing health program in a community with a spirit of coöperation has greater potentialities.

A STUDY OF THE HEALTH PROGRAM¹ IN THE LABORATORY SCHOOLS OF THE UNIVERSITY OF CHICAGO

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The health program for pupils in the Laboratory Schools is the joint responsibility of classroom teachers, physical-education teachers, school physicians, and leaders of recreation clubs. It is informal in the kindergarten and first four years, and formal beginning with the fifth year. The program is described under three general divisions—Health Instruction, Body Mechanics, and Health Service and Supervision.

I. HEALTH INSTRUCTION

The Informal Program. Children in the junior and senior kindergartens are under the direction of kindergarten teachers throughout the school day. With junior groups much emphasis is placed on the formation of desirable habits of personal hygiene and practices conducive to health. Children are closely supervised in order that proper habits, practices, and regularity may be established promptly.

Following the toilet period the children retire to a well-aired room where they have a cup of water served in individual cups. They then obtain their own rugs and lie down for a rest period of fifteen minutes daily. Instruction and supervision in the proper use of lavatories suggest that hands are washed before the relaxation period.

Due emphasis relating to desirable health practices in the junior kindergarten simplifies somewhat the problems in the senior kindergarten and early elementary years where health habits are given an important place. In these grades health instruction has emphasis as

¹ *Physical Education and Health of School Children*. Publications of the Laboratory Schools, University of Chicago, May 1936.

the occasion requires in both academic and physical education. Instruction is generally individual as the teacher observes the need for health information and improved health practices. Group instruction is provided as there is opportunity for class discussion and activities.

The Formal Program. Formal health instruction in the form of a special course is offered in the fifth year and in selected units in science courses of the high school. In lower grades little attention is given to the reasons for the health practices which children are required to observe. At the fifth-grade level sustained interest in health habits and practices demand an understanding of the principles on which the laws are based.

The plan of instruction for the fifth-grade and high-school science classes follows closely that described by Professor H. C. Morrison² for instruction in science-type subjects. To get best results each teacher modifies and adapts instruction to the situation which has developed. Variations in method aim to secure some emotional reaction or skill not readily obtained by the science-type procedure.

Each unit in a science course is selected to bring about some improvement in thinking and behavior. Pupil activities are selected by the teacher. As a rule they are incorporated into assignment sheets or "Guide for Study" for the use of individual pupils.

The classroom procedure as described consists of four phases: (1) preparation for study, (2) study, (3) evaluation of results, and (4) application of newly acquired knowledge. Details of procedure depend on the teacher and the unit studied. There is no sharp division of time between laboratory and recitation periods.

The Fifth-Grade Health Course. The course in health education³ for the fifth grade has a time allotment of thirty minutes a day during one semester. The teaching procedure consists largely of experi-

² Henry C. Morrison, *The Practice of Teaching in the Secondary School* (revised; Chicago: The University of Chicago Press, 1931).

³ The terms health instruction and health education are apparently used synonymously.

ments by the children and demonstrations by the instructor in the science laboratory. The units of work are so outlined that each pupil may progress at his own speed. The course includes a study of first-aid materials and practices, the heart and circulation, respiration, exercise, fatigue, posture, digestion, foods, and food content.

II. BODY MECHANICS

In addition to health instruction there is a program in "body mechanics" or "the mechanical correlation and functioning of the various systems of the body." This program, much more extensive and thorough than in most school systems, is largely preventive. Children in need of corrective treatment are given special attention within their respective groups. Appropriate activities within the regular physical-education program are considered more effective than those of special corrective classes.

Improvement in Posture. The problem of preventing poor posture belongs to the teachers and school physicians. In solving that problem there is a felt need for a clear understanding on the part of pupils as to the conditions and practices which affect posture. During physical examinations the physician rates each pupil for general posture—excellent, good, poor, or bad, according to standards published by the Children's Bureau of the United States Department of Labor. Although not precise, these ratings are helpful in arousing a pupil's interest in improving his postural positions.

Education in Body Mechanics. Education in body mechanics starts during physical examinations when pupils begin to learn the meaning of good posture. Many fail to assume and maintain good posture because they are unable to recognize it in others. In attempting to demonstrate good posture children often assume strained and unnatural positions which they cannot and should not maintain. During the physical examinations on or near a child's birthday the physician tries to make him "posture conscious" and to explain the importance of good body mechanics.

All teachers assist in carrying out this program in elementary grades. Aside from keeping the children conscious of their posture, they work with individual pupils. Children with defective hearing or sight are so placed in classrooms that their defects may not force them into strained positions in attempting to hear or see.

In connection with the related subject matter the pupils are instructed to assume the correct sitting and standing positions. They rate each other, make drawings to illustrate excellent, good, poor, and bad postures, and list the body positions described in each illustration. They write a paragraph to show their attitude toward and knowledge of body mechanics. At the end of the unit of study test questions on body mechanics are answered by the pupils.

Occasional meetings of parents are used for lectures and discussions of body mechanics. These meetings help parents to understand the school program and bring about better coöperation between the home and school. Parents are informed of the relation between posture and general health, nutrition, fatigue, sleep, rest, diet, disease, clothing, and exercise. As many of these factors are beyond the control of the school, the coöperation of parents is of great importance.

III. HEALTH SERVICE AND SUPERVISION

Health service and supervision is provided by two full-time physicians. A woman physician examines the girls and a man physician the boys, but this division is not always observed in caring for pupils. There are two or more physical examinations during the year; one at the beginning of the school year, a more thorough one on each child's birthday, and special examinations as occasions require.

Medical History. For educational and medical purposes a medical history seems of great importance, especially for young children. This includes data concerning birth, development, habits, and social and emotional problems. All information of this nature is recorded on the pupil's master card which serves as a cumulative record.

First Aid. Although school physicians render first-aid service of all kinds they are chiefly concerned with the care of injuries. In a case of serious injury, necessary first aid is given and the parents are advised to have the child treated by their own physician.

Other Health Problems. In addition to physical examinations and first-aid service the physicians determine which pupils shall be excused from physical activity. They restrict also the use of the swimming pool and showers, and are largely concerned with the control of communicable diseases.

CRITICAL REACTIONS TO THE HEALTH PROGRAM IN THE LABORATORY SCHOOLS

Although necessarily brief, the above description of the health program in the Laboratory Schools may serve to suggest improvement of health education in other situations. The close integration of physical education and the health program seems most commendable. Although perhaps too detailed and expensive for general adoption, certain divisions of the health program have many worthy features.

Through the employment of two full-time physicians, an hour is allotted for the physical examination. This liberal provision is in wide contrast to that in many public schools where children are too often examined at the rate of one a minute. It may be doubted, however, whether a health program can be entirely satisfactory without the services of a dentist and at least one dental nurse. It is claimed that the program in Body Mechanics is largely preventive, yet no mention is made of the overwhelming need for dental service.

Health Instruction versus Education. The issue may be raised as to the extent which this program involves health education beyond the fourth grade. It has long been axiomatic that knowledge about desirable health practices has little relation to its application. A child may understand the need for dental cleanliness, the right selection of foods, and fresh air in his bedroom without putting

forth any effort to apply this knowledge. His home environment, so closely bound up with family habits, attitudes, and financial problems, is a far more potent determiner of behavior than anything learned at school. A test in science does not measure individual practices.

Although formal instruction beginning with the fifth year has an important place in health education, it may be doubted whether this alone is sufficient in higher elementary grades or even high school. Most school systems include pupils of widely different social, racial, and economic levels, where both formal and informal types of teaching are absolutely necessary.

Naturally, the health program is adapted to the needs of pupils, but if the health situation in Chicago varies widely from that found in most school systems, that fact should be stated. From the description one is led to conclude that pupils are largely molded and fashioned as inanimate objects rather than living human beings. A much larger responsibility for health education and accident prevention will gladly be assumed by the children than is usually permitted them. There are many classroom problems which the children can help to solve but no reference seems to be made to them. Nothing is said about provision for school lunches or how they are conducted.

Accident Prevention. No program of health education seems complete unless it includes the teaching of accident prevention. In most schools considerable emphasis is placed on traffic hazards and making the child conscious of dangers about him. General rules and advice about crossing streets, playing in public highways, "hitching rides," and other dangerous practices should be understood by children. They can with profit be repeated at frequent intervals. Safety education must be regarded as an essential of the present-day curriculum, the application of which should largely be assumed by the pupils themselves.

Mental Health. It may properly be assumed that health is a wholesome type of living. The curriculum provides a series of experiences

through which the child learns to live wholesomely and purposefully. Education in general and health education in particular should concern itself with the child's total development, both physical and mental. Every activity during the child's day and every school situation influences the child for good or bad. Due recognition of this relationship does not appear in the health program for the Laboratory Schools.

Although textbook knowledge is important, it is even more essential "that the child be taught to live at peace with himself and those about him." Otherwise his energies may be utilized in mental and physical conflicts until he has little energy left with which to make a contribution of his own. Children in need of mental adjustment may be found in all groups regardless of general ability but few teachers are trained to discover them. A health program which concerns itself chiefly if not wholly with physical welfare fails to recognize the child's emotional needs and strivings. A child's attitude is changed through influences from within rather than from those projected upon him by outside forces.

NEW TRENDS IN SOCIAL RESEARCH—SOME HYPOTHESES AND SOME SOCIOMETRIC SCALES

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Ignorant and illiterate people sometimes purchase pince-nez because they consider the possession and display of these things proof of refinement and high social status. Thus they interpret the meaning of nose glasses as articles of adornment, serving much the same purpose as a necklace, a brooch, a stickpin, or a membership emblem, being aware only vaguely of the real functional purpose of the glasses, which is to correct imperfect vision. How many professional people, teachers, and social workers approach their professional activities in the same thoughtless spirit and vague understanding? What is the functional purpose that justifies social work or teaching? Is social work justified because it attains certain objectives that promote individual adjustment and social welfare? If so, are the objectives of each form of social work, as well as teaching, clearly stated, widely understood, and generally accepted? Much of the value of social and educational effort assumes clearly stated objectives, wide understanding of these, and general agreement on their value.

It is upon such an assumption as this that people contribute to the support of private social agencies and private schools by gifts, and to the support of public social agencies and public schools by tax payments. Should not they insist that there be some test of the results other than the verbal opinions of the executive head of the agency or the annual report of the school superintendent? Is it a question of the people's getting their money's worth? Do they get their money's worth? Or is that the question which really matters?

Why bother with statistics, accounting, or social audit? Sufficient

unto the technique is the pleasure thereof. If it costs money to support a social program, a social agency, or an educational activity, is not the valid justification to be found in the paid employment it gives to teachers and social workers and in the time-killing values of protracted board meetings, or in the illusion of social usefulness it creates in the minds of leisure-class or lay persons who serve on boards? Teaching and social work give many people something to do. Social work particularly deals with relations that are emotionally stimulating and satisfying because they consist of human contacts that a fast encroaching machine environment threatens to curtail, not by the elimination of them, but in making them more artificial and less real. Thus social work revivifies life by making it possible to bring into the range of personal experience human contacts otherwise denied to many fortunate individuals in the economically more secure social classes. To be sure, much of this experience is vicarious, but even so it is vastly more real than reading a novel of how the other half lives.

These questions may, of course, be dismissed as cynical. But is the problem as simple as that? Who will deny the social values of direct personal contact in informal interviews, or the sense of well-being that people experience in settlement-club work? Is not satisfaction in performance on the job after all a reasonable justification for much social work and teaching, both by professional and lay persons?

Suppose we shift the point of our scrutiny of motivation to the area of preventive medicine and ask the question whether vaccination and quarantine are such pleasurable activities for public-health workers as to be their own justification. The absurdity of the matter is at once evident. But does not the juxtaposition of these incongruous things bring us back to the question of function? To what extent are we doing social work or teaching because of satisfaction in its performance, and to what extent are we doing social work or teaching because it leads to *certain gains* that are as valuable to the

individual treated as is the sure prevention of the spread of infections by the use of public-health measures? Let us not confuse the two functions and try to justify the pursuance of one by the satisfactions of the other.

Educators who try to be honest with themselves have come to the conclusion that systematic school education does not raise the level of intelligence by training all children in the acquisition of knowledge and mental skills. The educational system seems to act as a selective agency that in successive years screens out those who are incapable of further improvement or learning. Except for those individuals who have lacked opportunity for continued education and those who have dropped out because of economic or other external circumstance, the amount of education in years that a person has achieved is a fair measure of mental ability. There are, of course, some exceptions whenever institutions of low standard promote individuals of mediocre mental ability. In such cases the possession of an education is merely the possession of an emblem of adornment which it is expected will elicit from associates reactions of approval that are ordinarily called forth by any evidences of high social status. Here the real social function of education is obscured or misunderstood.

The questions we have raised about the justification for teaching or for social work bring us inevitably to the further query: To what extent does the existence of a vaguely worthy end justify increased skill in the performance of an ineffectual service? Unless the objective is clearly defined how do we know that efforts to improve our skill and technique are not efforts that enable us to do with greater and greater satisfaction a job that is not worth doing because it is not oriented to a clearly defined and attainable end? Why not give more time to efforts to check up on or measure the degree to which our means achieve pragmatic ends?

The substance of the foregoing remarks is to suggest that in education we have underestimated the part that original native ability

plays in formal education, and to suggest that in social work we have underestimated the role of natural recuperative social processes of an all-surrounding society in the restoration of maladjusted individuals. May we not be justified, therefore, in the hypothesis that there exist in society certain natural recuperative processes that do operate through social absorption to effect restoration? We have only begun to utilize these processes in social casework therapy and in social group-work therapy.

We need methods by which we may describe these natural recuperative social processes. They have not been described adequately by the techniques of social casework and group work. Fortunately sociologists and some social workers have begun the construction of tools of research that can be used to describe these processes.

But before going on we need to distinguish between tools and methods, between instruments and procedures. Doctors use a direct *method* of interview to obtain information as well as a laboratory *method* of blood analysis. Doctors also use such *tools* or instruments of description as a mouth thermometer, a stethoscope, a machine to measure the patient's blood pressure, etc. These *tools* are instruments of precision that give precise description of some of the patient's symptoms. A Negro or a white nurse will get the same result by testing the temperature of the same patient when using a standardized thermometer. A Jewish or Catholic doctor gets the same result on the same patient with a Wassermann test.

Now the various sociometric scales to measure attitudes, adjustment, morale, home environment, social status, and participation are in reality *tools or instruments of observation* just as truly as are the mouth thermometer, the stethoscope, etc., of the doctor. These tools also are standardized! *They are reliable*—for example, the social-status scale repeated on the same homes gives the same results by the same observers or by different observers. Correlations of scores by the same visitor, B1B2, give $r=+.98$; and M1M2 give $r=+.99$. Correlations of scores by two observers, B, M, give

$r = +.90$; two visits, V_1V_2 , give $r = +.98$ on 46 Indianapolis homes by students. *They are valid*—viz., the social-status scale correlates with the independently made judgment of visitors of the Minnesota State Children's Bureau on 29 foster homes: $C = .61$, Bi-serial $r = .67$. Even subjective part II of the social-status scale, on condition of the living room gives: V_1 and V_2 , reliability of $r = +.97$ on 46 Indianapolis homes by students, $r = +.96$ on 29 St. Paul homes by CWA visitors, $r = +.72$ on 50 Minneapolis relief homes B_1M_1 ; and for validity a bi-serial r of $+.47$ on 13 variable classes for 41 homes use overcrowded with 24 homes non-use overcrowded.¹

In short we have now ready some sociometric scales that are instruments of somewhat precise observation. Unfortunately, these sociometric tools are for the most part unused by sociologists and social workers in research and practice.

The reasons why these sociometric scales are not used more in social research or by social workers in practice need to be examined. Ignorance of their existence is one reason. Many sociologists are still preoccupied with research in pure theory, or in the "exploratory descriptive research" of surveys and population counts. Most social workers are preoccupied with problems of the minute. Resistance to the use of these scales exists. The lack of scientific training of most sociologists and their neo-scholastic ideologies are obstacles. Social workers resent the implication that these scales or mechanical devices can supplant individual judgment based on practical professional training and successful experience.

But the point is these sociometric scales are not intended to supplant individual judgment of the competent professional practitioner.

Do the thermometer and stethoscope destroy the role of the skilled physician and make it possible for one to call in the janitor

¹ The means on part II were: $-7.43 = M_1$ for 41 use-overcrowded homes;
 $-0.58 = M_2$ for 24 homes with living room not otherwise
 used.

or a plumber for medical services? The thermometer and stethoscope merely supplement the judgment of the experienced physician by supplying additional diagnostic instruments of observation and precision. Similarly, the sociometric scales are supplementary diagnostic instruments to aid in diagnosis.

Granting this, of what practical value then is a given scale in diagnosing or in treating a single maladjusted individual? You do not put the scale into his mouth; how then do you use it? The answer is, first, that the readings on the scale give us a community norm for comparison; secondly, we obtain a score on an individual or person or family or home; thirdly, we may then find out how far our individual case departs from the norm of the community or neighborhood; and finally, we may find out whether our client is less or more abnormal or adjusted *after our treatment*.²

These normal or natural recuperative social processes mentioned earlier—just what are they; how can they be described for purposes of research or professional practice? The sociometric scales that give us readings on the social situation, on the neighborhood, on the environment of the community supply the means whereby we may identify these natural recuperative social processes, because they enable us to compare the individual with the community trend or norm. Let us consider a series of propositions to illustrate this.

The effect of lack of normal social contacts with the group life and institutions of the neighborhood and the community is to isolate the individual and to cause personal maladjustment and low morale.³ The effect of lack of normal reciprocities of personal relationship within the family is to weaken its cohesion and organization.⁴ The effect of going up or down socially is tied into the

² Consult F. Stuart Chapin, "The Effect of Slum Clearance on Family and Community Relationships in Minneapolis," *American Journal of Sociology*, 44:5 (March 1938).

³ *Scales to measure* (1) amount of group contact and (2) the psychological effects are: Social participation scale (Chapin), group adjustment scale (Newstetter), attitude scales toward the family, the school, the church, etc. (Kirkpatrick, Thurstone, etc.), general adjustment scale (Sletto), morale scale (Sletto).

⁴ *Scales to measure*: Kirkpatrick, Mrs. Bernard, etc.

presence of inferiority feelings, internal conflicts, neurotic reactions, and maladjustment of the individual.⁶ The effect of successful foster-home placement is to secure adjustment by placing the child in a home that is itself an organic part of the neighborhood or community in which it is situated so that the foster child picks up naturally the contacts and status of the home and is absorbed into the community by its natural recuperative social processes. Consequently, the foster home should not have such a high social status that upon the child's return to contacts with relatives he feels superior to them or dreads to be demoted socially.⁶ Examples of the use of sociometric scales to describe the fabric of community relationships which is the environment of persons either in a rural community, a village, or a city are cited in the list of references that follows. These examples suggest how such scales may be used to describe the assumed natural recuperative social processes of an all-surrounding society.

SELECTED REFERENCES ON SOCIOMETRIC SCALES TO MEASURE
THE SOCIAL TRAITS LISTED

1. *The family (scales not calibrated)*

Jessie Bernard, "An Instrument for the Measurement of Success in Marriage," *Publications of the American Sociological Society*, XXVII (May 1933), 94-106.

Clifford Kirkpatrick, "Community of Interest and the Measurement of Marriage Adjustment," *The Family*, 18: 4 (June 1937), 133-137.

2. *Friendship choices and constellations (not scales, only method)*

George A. Lundberg and Margaret Lawsing, "The Sociometry of Some Community Relations," *American Sociological Review*, 2: 3 (June 1937), 318-335.

J. L. Moreno, *Who Shall Survive? A New Approach to the Problem of Human Interrelations*. Washington, D. C.: Nervous and Mental Disease Publishing Company, 1934, xvi + 440 pages.

Sociometry, Vol. I, no. 1-2 (Beacon, N. Y., P. O. Box J), contains many articles illustrating the Moreno technique.

⁶ *Scales to measure*: (1) Going up or down socially, Mrs. Shea's scale to measure urban home environment; Chapin's social status scale; (2) reactions of adjustment and morale, Rundquist-Sletto scales.

⁶ *Scales to measure*: Social status scales or scales of home environment; social participation scale (Chapin).

3. *Home environment and social status (score cards and calibrated scales)*

Dorothy Dickins, "Living Rooms of Low-Income Farm Families of Mississippi," *Journal of Home Economics*, 29: 10 (December 1937), 702-709. (Uses Chapin scale.)

F. Stuart Chapin, *The Measurement of Social Status* (Minneapolis: University of Minnesota Press, 1933).

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F. Stuart Chapin, *The Social Participation Scale* (Minneapolis: University of Minnesota Press, 1937).

Alice Leahy Shea, *The Measurement of Urban Home Environment* (Minneapolis: University of Minnesota Press, 1936).

Alice Leahy Shea, *The Minnesota Home Status Index* (Minneapolis: University of Minnesota Press, 1936).

V. M. Sims, *The Measurement of Socio-Economic Status* (Bloomington, Ill.: Public School Publishing Company, 1928).

V. M. Sims, *Sims Score Card for Socio Economic Status*.

4. *Morale and general adjustment (calibrated scales)*

E. A. Rundquist and R. F. Sletto, *Personality in the Depression* (Minneapolis: University of Minnesota Press, 1936), 398 pages.

E. A. Rundquist and R. F. Sletto, *Minnesota Scale for the Survey of Opinions* (mimeographed short form) (Minneapolis: University of Minnesota Press).

5. *Neighborhood (score card not calibrated)*

Jessie Bernard, "An Instrument for the Measurement of Neighborhood with Experimental Applications," *The Southwestern Social Science Quarterly*, 18: 4 (September 1937).

6. *Play group (technique of study, no score card)*

W. I. Newstetter, "An Experiment in Defining and Measuring Group Adjustment," *American Sociological Review*, 2: 2 (April 1937), 230-236.

7. *Participation in clubs, groups, and institutions (score card)*

F. Stuart Chapin, *The Social Participation Scale* (Minneapolis: University of Minnesota Press, 1937).

BOOK REVIEWS

Mentality and Homosexuality, by SAMUEL KAHN. Boston: Meador Publishing Company, 1937, 249 pages.

This study purports to be a scientific survey of the methods used in gathering data concerning incarcerated homosexuals in two of the institutions of New York City. The author, a former member of the psychiatric division of the New York City Department of Correction, studied about five hundred cases of which some seventy-five were selected for more detailed investigation. The study was made during the period, 1922-1926. The utter absence of truly scientific method renders the book valueless as a contribution to its field. It is unfortunate that so pertinent a problem should have been handled in such a weak manner. Dr. Kahn's conclusions are based largely upon his previous opinions and these are tinged deeply with a Freudian dye. The authors most frequently quoted include Kraft-Ebbing, Havelock Ellis, and Freud—an indication of the depth of the volume! The book lacks an index and one wonders just what happened to the proofreader.

Manual for Southern Regions, by LEE M. BROOKS. Chapel Hill: The University of North Carolina Press, 1937, 193 pages.

The *Manual for Southern Regions* is designed to accompany *Southern Regions of the United States*, by Howard W. Odum, and is a workbook. It is an indispensable guide to the use of the original volume as a text in university classes since it consists of numerous questions primarily on facts and monograph interpretations. It also provides space for notes of the student and makes possible an effective use of the larger text. It is of value mainly to the student of the larger text as a class aid.

The League Fiasco, by VICTOR MARGUERITTE. Translated by Mrs. N. MACFARLANE. London: William Hodge and Company, Limited, 1936, 284 pages.

Hundreds of books have been written about the League: a cold summary of events, an impassioned defense, or a bitter denunciation. This book falls in none of these categories despite its title. It does summarize the rise and fall of the League but the recording of events is subordinated to their significance as both cause and effect. The League is denounced

and defended with the skill of a jurist. The annihilation of Wilson's 14 Points, the heritage of hate in which it was launched, and the failure of sanctions form the debit side of the ledger; the long struggle of mankind for some guarantee of peace, the ideal of collective security, and the non-political accomplishments of the League comprise the credit on the balance sheet. The League is dead; long live the League! Not the League born in hate and dominated by economic imperialism; but a League to be reborn in the spirit of justice and controlled by humanitarian principles.

The Price of European Peace, by FRANK DARVALL. London: William Hodge and Company, Limited, 1937, 181 pages.

The author of this extremely thought-provoking little volume has made a brutally frank analysis of the policies and present status of both the "have" and the "have-not" nations. He has proposed a sweeping reorganization of international relations not on the basis of the now discredited League of Nations, but with a new and powerful centralized government. The book will be criticized by those who support present imperialistic policies as well as by the realists who assert that lesser problems must be attacked first. May it not be, however, that the world has advanced so near the abyss of another holocaust that no mere patching can avoid the final rending of the veil of Mars?

Introduction to the Social Studies: an Elementary Textbook for Professional and Preparatory Groups, by JOSEPH K. HART. New York: The Macmillan Company, 1937, 203 pages.

This book is designed for would-be members "of the social professions," doctors, nurses, lawyers, ministers, teachers, engineers, whom the author looks upon as potential teachers of the public because they will be "engaged in either strengthening or weakening the foundations of society." Professor Hart confines his treatment to the "skeletal framework" of the present-day social order, pointing out that to grasp its inner meaning and significance the student must resort to the various social sciences. These he names and characterizes in a concluding chapter. The essentially problem nature of society is emphasized and the student is impressed with his individual responsibility for solving its problems.

The Elements of Research, by FREDERICK L. WHITNEY. New York: Prentice-Hall, Inc., 1937, 616 pages.

This text represents a very valuable addition to treatments of this topic. Although the copious references and illustrations are taken largely from the field of education, the treatment is general in scope. The topics dealt with include: Thinking, Science and Research; Research Traits and Abilities; The Problem; Analysis of Previous Research; Research Procedures (Descriptive, Historical, Experimental, Philosophical, Prognostic, Curriculum, Sociological, Creative); Classification of Material; The Research Report. Each topic is thoroughly and soundly treated, with good practical emphasis and provision of thought-provoking exercises.

An Introduction to Modern Education, by CHARLES E. SKINNER, R. EMERSON LANGFITT, and others. New York: D. C. Heath and Company, 1937, 491 pages.

Books tend to appear in cycles. In 1928, three texts for orientation courses made their bid for the textbook field. In 1937, another group of texts has already been published. There is, however, a marked difference reflecting a fundamental change that has taken place in all education as well as in the orientation field: the new books give major attention to the sociological approach, stress the social function of the school, and emphasize the need of coördinating all of the agencies of the community.

The introductory chapter by Dean W. Withers forcefully presents this point of view; the various chapters on the specific problems of education present in detail the implications of this approach. The book will not only prove an excellent text, but will be of genuine value to teachers and administrators.

Newcomers and Nomads in California, by WILLIAM T. CROSS and DOROTHY E. CROSS. California: Stanford University Press, 1937, 149 pages.

The problem of the transient laborer is not new. Thousands of workers, often with large families, have trekked annually from place to place following seasonal agricultural employment. However, two new factors have materially changed the problem. One is the depression, made all the more acute for many by the ravages of the dust storms; the other is

the allotment of Federal funds through the Relief Act of 1933 and succeeding provisions for permanent, model camps for the transient worker.

This book is an interesting, factual description of the relief situation, legislative action, and the accomplishments of the "Nomad Camps." It is an important contribution to the field of social service.

Unemployment in the Learned Professions, by WALTER M. KOT-SCHNIG. New York: Oxford University Press, 1937, 347 pages.

With the exception of the U.S.S.R., some of the British Dominions, a few of the smaller countries of Europe, China, and the Latin-American countries, the work reports the high points of the world investigation of unemployment in the learned professions. It is significant that the survey was the "first attempt" to gather information throughout the world on a problem of such vital importance to society. A table on the increased frequency of students in total population of each country dispels any notion that the higher student enrollments might be laid to population increases. In fact, "the considerable increase in student enrollments coincides with a very marked decline of the birth rate in the Western countries," and "the prevailing low birth rate, therefore, foreshadows further high student enrollments." Numerous other interesting facts can be found throughout the work, which has brought together an extraordinary amount of factual material. The book constitutes an almost indispensable document for any one who wishes to understand where our higher education is heading.

Kit Brandon, by SHERWOOD ANDERSON. New York: Charles Scribner's Sons, 1936, 373 pages.

Kit Brandon is the story of the rise and fall, or perhaps redemption, of a female rum-running member of a gang in the prohibition era. Kit and Tom Halsey, her boss, are the protagonists, while the other characters are simply used as foils.

The book ends rather naïvely with the suggestion that Kit's problem will be solved by getting a job, and meeting "some one other puzzled and baffled one" with whom she could make a real partnership in living.

Comparing the book to a case record, we would say that Mr. Anderson has written a fairly good background of Miss Brandon, if one, of course, likes Mr. Anderson's choppy style. But her problem of adjustment in normal society is still unsolved.

Cooperative Democracy, by JAMES PETER WARBASSE. New York: Harper and Brothers, 1936, 285 pages.

The author has made an excellent, readable, yet factual analysis of the principles, methods, and accomplishments of coöperation. He summarizes the relation of coöperation to profit-making business, to various labor movements, and to the State. The concluding section on the larger possibilities of coöperation is a forward-looking statement of what the author envisions for the future of the movement.

Man, Bread, and Destiny, by C. C. and S. M. FURNAS. Baltimore: Williams and Wilkins Company, 1937, 364 pages.

Although not written specifically from the point of view of consumer education, this book is a very significant contribution to the literature in this field. In a delightfully entertaining style the authors present the effect of food upon world civilization, nations, and the individual. The chapter on "Gullible's Travels" is a clever arraignment of dangerous fads.

40,000,000 Guinea Pig Children, by I. M. ALPHER and RACHEL PALMER. New York: Vanguard Press, 1937.

This is another exposé of the spurious claims made by advertisers of commercial products such as foods, toilet accessories, and clothing. It contrasts such claims with the results of laboratory tests. It follows the general pattern of the earlier book, *100,000,000 Guinea Pigs*, but includes only commodities used for children.

Co-op, by UPTON SINCLAIR. New York: Farrar and Rinehart, 1936, 426 pages.

The author has, in this novel, departed from his usual controversial style. He has written an interesting and convincing story of a coöperative by realistic description of the people who work in it.

Fresh Furrow, by BURRIS JENKINS. Chicago: Willett, Clark and Company, 1936, 257 pages.

This is an excellent illustration of the utilization of the novel to mold attitudes so subtly that the reader is at no time aware of the real purpose. It is the story of a young college graduate and his experiences in the organization and development of a coöperative.

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